PRINTED: 11/07/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 11/02/2011 445298 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1234 FRYE STREET, PO BOX 786 LIFE CARE CENTER OF ATHENS ATHENS, TN 37371 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 : INITIAL COMMENTS F 000 During complaint investigation numbers 28771, 28886, and 28227, conducted on October 31, 2011, through November 2, 2011, at Life Care Center of Athens, no deficiencies were cited under 42 CFR Part 483.13, Requirements for Long Term Care. Dentist appointment was scheduled 12/2/2011 F 166 (483,10(f)(2) RIGHT TO PROMPT EFFORTS TO F 166 SS=D RESOLVE GRIEVANCES for resident #8 on November 16, 2011 to resolve any issues with A resident has the right to prompt efforts by the dental bridge secondary to incident. facility to resolve grievances the resident may have, including those with respect to the behavior All residents have the potential to be of other residents. affected, Social Services Director and/or Assistant Executive Director will conduct a 100% audit of all This REQUIREMENT is not met as evidenced grievances reported during the past year to ensure that prompt efforts by: Based on medical record review, observation. were made by the facility to resolve and interview the facility failed to resolve grievances. Any grievances found grievances for one resident (#8) of twenty-seven unresolved will be followed-up on residents reviewed. and resolved promptly. The findings included: 3. Social Services Director and/or Executive Director will inservice staff Resident #8 was admitted to the facility on July 1, on the facility's policy and 2010, with diagnoses of Multiple Sclerosis, procedures for managing Paraplegia, Osteoporosis, and Chronic grievances, Social Services Director Constipation. and/or Staff Development Coordinator will educate new staff Medical record review of the Minimum Data Set on orientation of the facility's policy (MDS) dated August 28, 2011, revealed the and procedures for managing resident was unable to bear weight, and required grievances. Executive Director will moderate assistance with transfers and activities continue to review all concern and of daily living and was independent in daily comment forms to ensure decision making. grievances are being resolved promptly. Social Services Director

Interview with the resident on October 31, 2011. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XB) DATE

Executive

and/or Assistant Executive Director

11/16/20

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

445298

PRINTED: 11/07/2011

FORM APPROVED OMB NO. 0938-0391

## DEPARTMENT OF HEALTH AND H AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OMB NO. 0930-03:
(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
A. BUILDING	-
B, WING	11/02/2011

11/16/2011 19:29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1234 FRYE STREET, PO BOX 786			
LIFE CAI	RE CENTER OF ATHENS		,	ATHENS, TN 37371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	·IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 166	Continued From page 1 at 8:59 a.m., in the residents room revealed, the resident stated on January 28, 2011, in the facility shower room, the resident was accidentally struck in the face with the arm of a Hoyer Lift, (a mechanical lift used to transfer residents) chipping the resident's dental bridge. Continued interview revealed the resident had reported the incident to the facility and complained it had not been resolved.  Medical record review of the facility Concern and Comment Form, dated January 31, 2011, revealed, "stated that CNA (Certified Nurse Aide) hitin mouth with Hoyer lift and chippedbridge."	F	166	will conduct audits of all resident grievances monthly times three months to ensure that prompt efforts were made by the facility to resolve grievances.  4. Audit results will be given to the Executive Director and will be reviewed in the monthly performance improvement meeting for three months or until 100% compliance is achieved.		
	Progress Notes dated January 31, 2011, revealed, "would review the schedule and check who was working on that particular day and re-educate on operating lift."  Review of facility Policy, Abuse Prevention Managing Incidents and Falls revealed, "Falls & (and) incident management policies include the followingfloor nurse completes initial incident report. The initial incident documentation must first describe who, what, where, and when regarding the fall/ incident in the medical recordan accident incident report wil be complete whenever an accident or incident happens, no matter how minor or major the incident/accident may be."  Interview with the Director of Nursing (DON) on November 2, 2011, at 11:00 a.m., in the conference room, confirmed the incident had not		•			

been documented in the medical record and no

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DEPARTMENT	OF HEALTH	AND how	AN SERVICES
CENTERS FOR	MEDICARE	& MEDICA	ID SERVICES

FORM APPROVED OMB NO. 0938-0391

445298	В. V	WING			
1 1000			<del> </del>	11/0	2/2011
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF ATHENS	(40)	123	EET ADDRESS, CITY, STATE, ZIP 34 FRYE STREET, PO BOX 78 FHENS, TN 37371		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORM	FULL PR	ID REFIX FAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 166 Continued From page 2 investigation for the resident complaint completed.  F 278 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFE The assessment must accurately reflect resident's status.  A registered nurse must conduct or code each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certife assessment is completed.  Each individual who completes a portion assessment must sign and certify the atthat portion of the assessment.  Under Medicare and Medicaid, an indivivalifully and knowingly certifies a material set statement in a resident assessment subject to a civil money penalty of not must sign and false statement in certify a material and false statement resident assessment is subject to a civil penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute material and false statement.  This REQUIREMENT is not met as every by:  Based on medical record review and in the facility falled to ensure the Minimus.	had been  FIED  It the  ordinate  y that the  couracy of  idual who ial and int is nore than vidual who individual t in a ii money ch  ite a	F. 166	<ol> <li>Resident #5 had MD the 10/11/2011 quart assessment to includ which occurred on 9/Coordinator complete attestation on 11/4/2</li> <li>All residents have the affected. MDS Coord Assistant Director of conduct a 100% audi MDS assessments for days to ensure that the assessments are cooffor falls. Modifications completed on any assigned inaccurately conducted in the coordinators on process which included for Nursing printing a monthly and providing MDS coordinators to falls are recorded accoordinators will continued the medical records for documentation of falls to attend the events resident falls are revial assessments for accurately conducted the sevents of audit 10% of all reside assessments for accurately times the second of accurately conducted the events of audit 10% of all reside assessments for accurately times the second of a conducted the second of audit 10% of all reside assessments for accurately times the second of the second of a conducted t</li></ol>	erly e the fall, 5/2011. MDS ed this 5/1011.  e potential to be inator and/or Nursing will t of all resident or the last 90 nat the ed accurately s will be sessments ded for falls.  ad/or Assistant ill inservice the new es the Director calls report g a copy to the ensure that curately. MDS inue to review or the s and continue neeting where ewed. Nursing will ent MDS irrate coding for	12/2/2011

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DEPARTMENT OF HEALTH AND I JAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO		STRUCTION	(X3) DATE S COMPLE	
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	twenty-seven residence the findings included Resident #5 was at 28, 2009, with diagonal Hemiparesis, Stroke Medical record revious 11, 2011, revealed the prior assessment Medical record revious September 5, 2011	e for one resident (#5) of ents reviewed. ed: dmitted to the facility on August noses including Right	F 2	D re pe	udit results will be give irector of Nursing and eviewed in the monthly erformance improvem or three months or unti ompliance is achieved	will be ent meeting I 100%	
	revealed, "res was parameter (fall mail parameter (fall mail line). Interview on Nover with Registered Nu office, confirmed the 2011, did not reflect September 5, 2011 not accurate.  483.60(a),(b) PHAIL ACCURATE PROC	ad September 4, 2011, as observed laying on back on tress").  The second laying on back on tress").  The second laying on back on tress").  The second laying on back on tress"  The second laying on back on tress").  The second laying on back on the second laying layi	F 42	re id re th # pr ac	lo adverse reactions a esidents #9 and #12 w dentified. Nurses who responsible for the admine medications for residual be educated or olicy and procedures focurate acquiring, recispensing, and admini harmaceutical service	vere were hinistration of idents #9 and the facility's for ensuring eiving, stering of	12/2/2011

PRINTED: 11/07/2011

CENTERS FOR MEDICARE			( <b>.</b> ■ 1)		0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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NAME OF PROVIDER OR SUPPLIER	ens	1:	EET ADDRESS, CITY, STATE, ZIP CO 234 FRYE STREET, PO BOX 786 THENS, TN 37371		
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(including procedur acquiring, receiving administering of all the needs of each. The facility must enalicensed pharma on all aspects of the services in the facility failed to services in a timely and #12) of twenty. The findings including Resident #9 was a 27; 2009 with diagrammunodeficiency. Medical record reviation Record 2011, revealed H.I.V.), was not adrand August 1, 2011 treat H.I.V.), was not 2011, and Prevista	ide pharmaceutical services res that assure the accurate g, dispensing, and drugs and biologicals) to meet resident.  Imploy or obtain the services of cist who provides consultation e provision of pharmacy lity.  INT is not met as evidenced record review and interview, provide pharmaceutical manner for two residents (#9 seven residents reviewed.  Ided:  Idmitted to the facility on August nosis of H.I.V. (Human	F 425	<ol> <li>All residents receiving pharmaceutical service potential to be affected Nursing conducted a 111/4/2011 of all reside administration records that accurate acquiring dispensing, and admir pharmaceutical service provided.</li> <li>Staff Development Co and/or Director of Nursinservice nurses and norientation of the facility procedures for ensuring acquiring, receiving, diadministering of pharm services. Unit manage audits of all resident madministration records three months to ensuraccurate acquiring, receiving, and administration records three months to ensuraccurate acquiring, receiving and administration in the month pharmaceutical serviced delivered.</li> <li>Audit results will be given Director of Nursing and reviewed in the month performance improvem for three months or un compliance is achiever.</li> </ol>	es have the d. Director of 100% audit on 100% audit on 100% audit on 100% are to ensure g, receiving, nistering of 100% audit of 100% are to ensure is pensing will new nurses on 100% accurate is pensing, and 100% accurate is pensing of 100% accurate is pensing accurate	

Interview with Licensed Practical Nurse #1,( the

PRINTED: 11/07/2011

DEPARTMENT OF HEALTH AND F. AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	(X3) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP		
		445298	B, WING		- 10		11/	02/2011
	ROVIDER OF SUPPLIER RE CENTER OF ATHE	ENS		1234 FF	ODRESS, CITY RYE STREET, NS, TN 3737		ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENT'FYING INFORMATION)	ID PREFIX TAG		(EACH CORF	ES PLAN OF CO ECTIVE ACTION ENCED TO THE DEFICIENCY)	N SHOULD BÉ E APPROPRIATE	COMPLETION DATE
F 425	medications) on No in the east wing nur medications were re were unavailable for Resident # 12 was January 10, 2010, of Osteoarthritis, and	or the administration of the ovember 1, 2011, at 3:55 p.m., raing station, confirmed the lot administered because they orr, the facility pharmacy.  admitted to the facility on with diagnoses including Pain, Chronic Obstructive	F 425			Ļ		
	(MDS) dated Februaresident was on a singular regimen.  Medical record revious Order dated Augus revealed, "omit 8	ew of the Minimum Data Set lary 19, 2011, revealed the scheduled pain medication Ew of a Physician Telephone t 22, 2011, at 9:00 p.m., p.m. dose of 5/500 mg (pain medication)			548			
SS=D	dated August 2011 receive Hydrocodo tablet on August 22 Interview on Nover Registered Nurse & Station, confirmed available and the famedication in a time 483.75(I)(1) RES RECORDS-COMPLE	ew of the Medication Record, revealed the resident did not ne/Acetaminophen 5-500 at 2011, at 8:00 p.m. with the Medication was not actify failed to acquire the air manner.  LETE/ACCURATE/ACCESSIB aintain clinical records on each	; F 514	1	for residen 2011 to res	t #8 on Nove solve any iss		12/2/2011
		nce with accepted professional		İ				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

11/16/2011 19:29

PRINTED: 11/07/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	DING	(X3) DATE SU COMPLÉ	
Security of Security Security	445298	B. WING	3	11/02	2/2011
NAME OF PROVIDER OR SUPPLIES			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
LIFE CARE CENTER OF ATI	HENS		1234 FRYE STREET, PO BOX 786 ATHENS, TN 37371		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL I.SC IDENTIFYING INFORMATION)	ID · PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
accurately docum systematically orgonical recommendation to ide resident's assess services provided preadmission sor and progress not this REQUIREM by:  Based on medic and interview, the complete and accresident (#8) of the The findings included and interview with diagnoral resident #8 was 2010, with diagnoral paraplegia, Oster Constipation.  Interview with the at 8:59 a.m., in the resident reported face with a Hoyer transfer residents.  Medical record residents, Notes, Notes, and Social documentation of	ectices that are complete; lented; readily accessible; and lenized.  If must contain sufficient intify the resident; a record of the ments; the plan of care and it the results of any leaning conducted by the State;  ENT is not met as evidenced al record review, observation, le facility failed to maintain curate medical records on one leventy- seven residents reviewed.  Ided:  Ided: Idea admitted to the facility on July 1, loses of Multiple Sclerosis, loporosis, and Chronic  In resident on October 31, 2011, line resident's room, revealed the leves accidentally struck in the leves accidentally struck in the Lift (a mechanical lift used to leview of the Physicians Progress lotes, Certified Nursing Aide I Service Notes revealed no	F 5	2. All residents have the affected. Staff Develop Coordinator will inserve the facility's policy and for managing incidents Director will send out a residents and/or their legal/appointed repres how to report incidents facility's incident mana and procedures.  3. Staff Development Co inservice new staff on the facility's policy and for managing incident Director and/or Admis Coordinator will educa and/or their legal/apporepresentative on admit to report incidents bas facility's incident mana and procedures. Direct and/or Assistant Direct will conduct audits of employee orientation monthly times three mensure that new staff educated on the facility procedures for manage Marketing Director and Executive Director will audits of all new residing educated on ho incidents based on the incident management procedures.	ement ice staff on procedures is. Executive is letter to entatives on a based on the igement policy cordinator will orientation of diprocedures is. Marketing sions are residents binted in procedures in the igement policy ctor of Nursing all new records in the igement policy ctor of Nursing all new records in the igement policy ctor of Nursing all new records in the igentative and in its including incidents. I conduct ent admission is three months its and/or their is entatives are we to report in the incidents i	

DEPARTMENT OF HEALTH AND F. AN SERVICES

LIFE CARE ATHENS AT7

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ging Incident incident mar ingfloor nu t. The initial i escribe who, ding the fall/	ts and Falls reveal nagement policies rse completes initi ncident documenta what, where, and	include the lal incident ation must when	F 514	Executive Director ar reviewed in the mont performance improve for three months or u	nd will be thly ement meeting intil 100%	
iew with the mber 2, 2011 rence room, documented	1, at 11:00 a.m., in confirmed the inci in the medical rec	the dent had not cord and the		j	90	,
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t t	SUMMARY ST ACH DEFICIENCE GUI ATORY OR nued From p ging Incident incident mar ingfloor nu t. The initial i escribe who, ding the fall/ d" iew with the mber 2, 2017 refice room, documented	SUMMARY STATEMENT OF DEFICIENT ACH DEFICIENCY MUST BE PRECEDED OF LISC IDENTIFYING IMPORTANCE OF DEPOSITE OF DEFICIENT ACH DEFICIENCY MUST BE PRECEDED OF LISC IDENTIFYING IMPORTANCE OF THE INCIDENT ACH	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GUI ATORY OR USC IDENTIFYING INFORMATION)  nued From page 7 ging Incidents and Falls revealed, "Falls & incident management policies include the ingfloor nurse completes initial incident. The initial incident documentation must escribe who, what, where, and when ding the fall/ incident in the medical	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GUI ATORY OR USC IDENTIFYING IMPORMATION)  THE PROPERTY OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  PREFIX TAG  F 514  ID PREFIX TAG  PREFIX TAG  F 514  Incident send Falls revealed, "Falls & incident send Falls revealed incident to incident to incident documentation must rescribe who, what, where, and when ding the fall/ incident in the medical d"  The with the Director of Nursing (DON), on mber 2, 2011, at 11:00 a.m., in the remote room, confirmed the incident had not documented in the medical record and the	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GUI ATORY OR LSC IDENTIFYING INFORMATION)  THUE FROM PAGE 7  ging Incidents and Falls revealed, "Falls & incident management policies include the ingfloor nurse completes initial incident to The initial incident documentation must escribe who, what, where, and when ding the fall/ incident in the medical documented in the medical documented in the medical documented in the medical documented in the medical revise of the medical documented in the medical documented in the medical record and the	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GUI ATORY OR LSC IDENTIFYING IMFORMATION)  Thued From page 7 ging Incidents and Falls revealed, "Falls & incident management policies include the ingfloor nurse completes initial incident to the initial incident documentation must esscribe who, what, where, and when dling the fall/ incident in the medical di"  1234 FRYE STREET, PO BOX 786 ATHENS, TN 37371  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 514  4. Audit results will be given to the Executive Director and will be reviewed in the monthly performance improvement meeting for three months or until 100% compliance is achieved.  GEACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 514  4. Audit results will be given to the Executive Director and will be reviewed in the monthly performance improvement meeting for three months or until 100% compliance is achieved.